CareFirst BlueCross BlueShield

PCMH
Primary Care Medical Home

Practitioner Compensation
September 19, 2011

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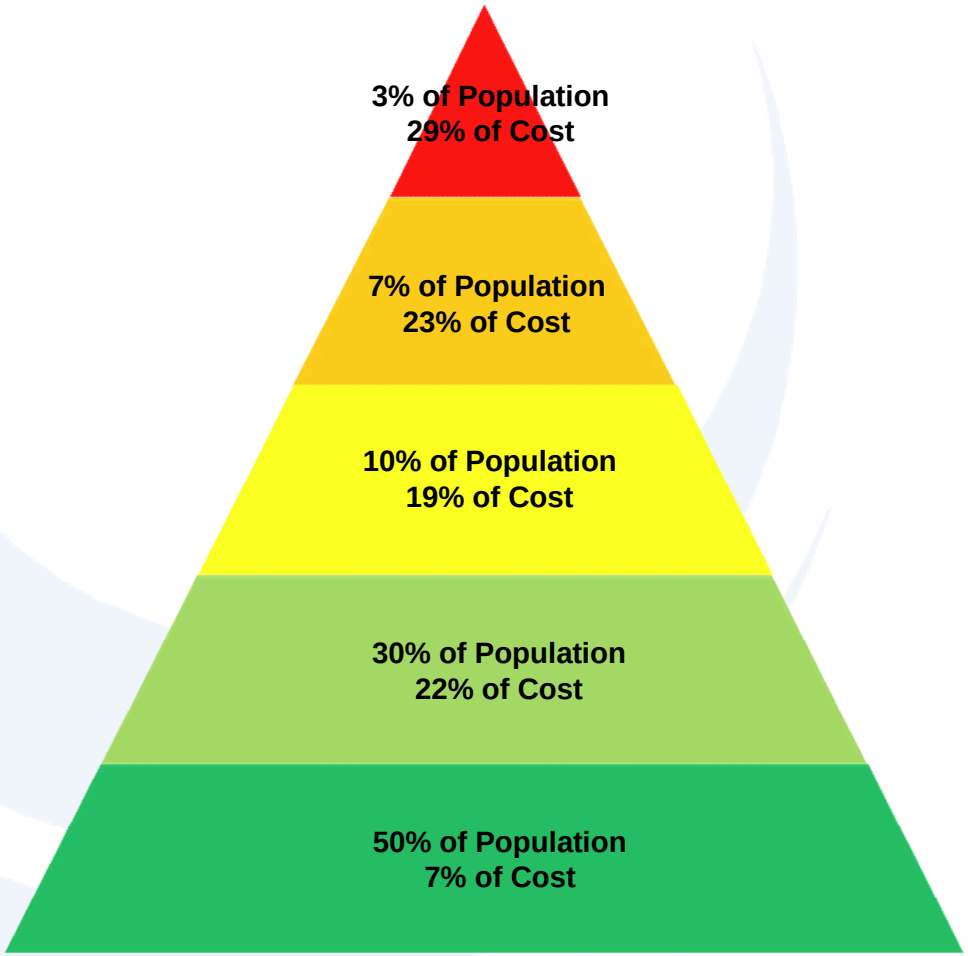
The Key Facts that Shape the Landscape

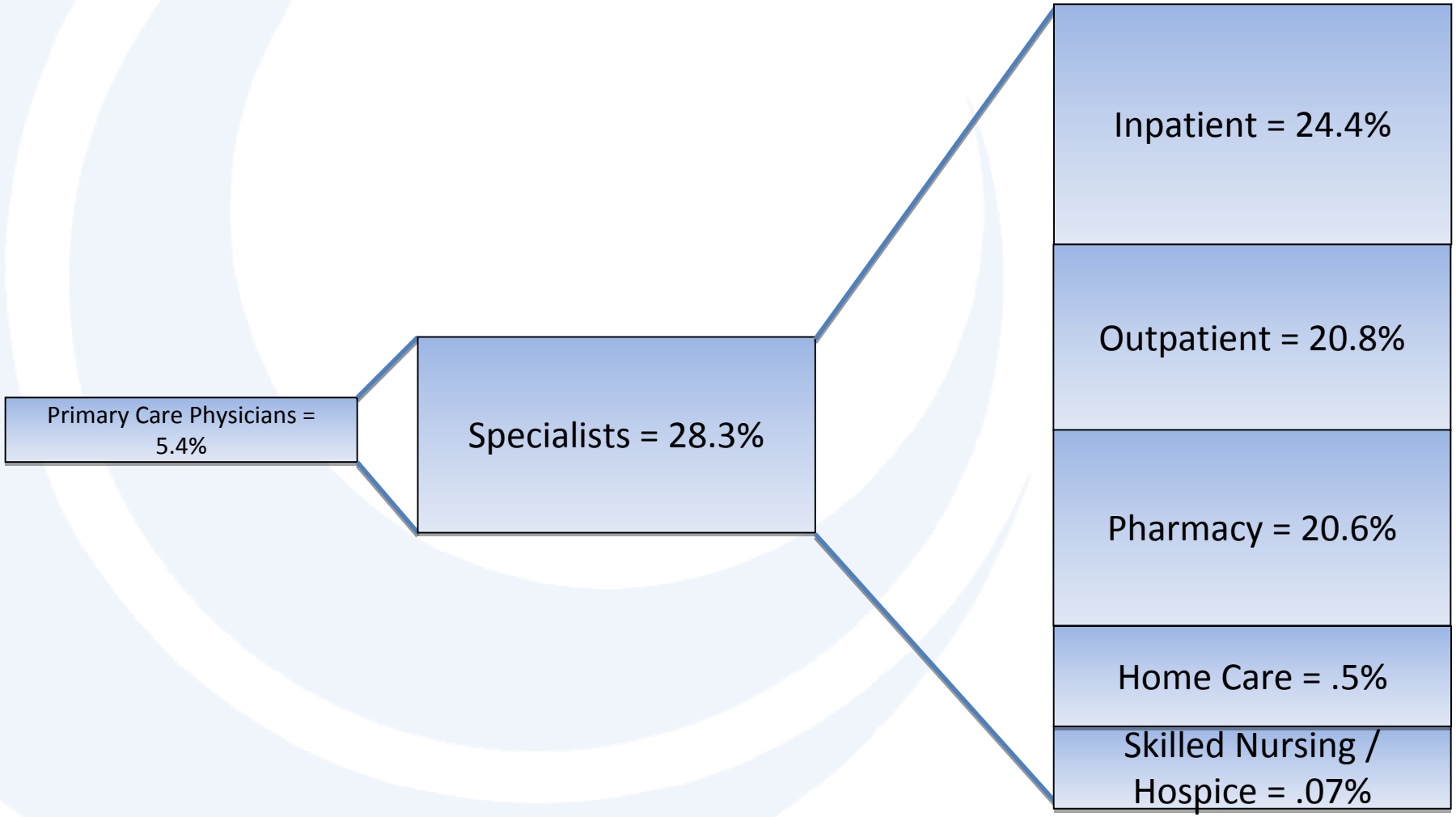
- Have seen continued upward force on costs of chronic disease – driven by aging, but also lifestyle
- Have seen largest health systems acquire smaller ones, employ MDs and congeal into oligopolies that cost more
- Independent PCP's are endangered – when employed by large systems, they are seen as inlet valves / feeders to specialists to fill the beds
- Role of the PCP is key
    - PCP is best for holistic understanding of the patient – particularly for management of chronic disease
    - Direct PCP services cost about 5 cents on the medical dollar
    - PCP's make the two most value-laden decisions in the whole health care system – when and where to refer – drive all outcomes and cost
    - However…PCPs are pressured – 10 minute encounters – quick to refer
    - No PCP downstream economic interest in the cost implications of their referral decisions

Illness / Wellness Pyramid – 2010 CareFirst Experience



Source: CareFirst Health Care Analytics

Medical Spending in 2010 – Distribution of the Medical Dollar



Source: CareFirst Health Care Analytics

PCP Compensation in CareFirst Primary Care Medical Homes

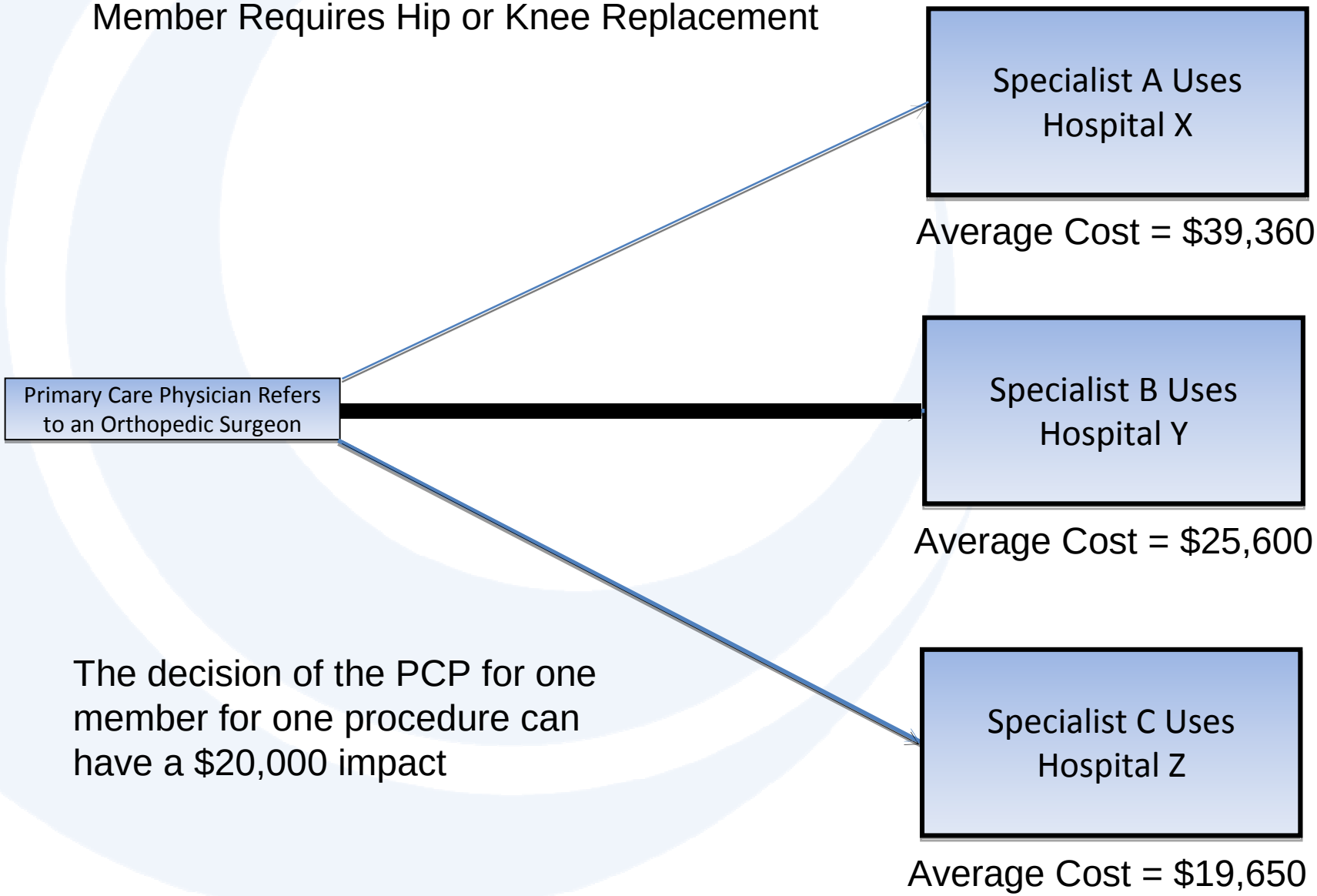
- Three elements to PCP Compensation Change:
  - 12% Increase in Current Fee Schedule
  - New Billing Codes for Care Plan Development & Maintenance
  - Outcome-based Incentive Award
- Causing PCPs to Focus on the Sickest Patients
- Enrolling Nurse Practitioners in PCMH with Similar Fee Opportunities
- Nurse Practitioners Have Been Eligible to Join CareFirst Networks for Almost a Year

Critical Role of the PCP in Managing Cost

- PCP's have a tremendous impact on the downstream costs that will be reflected in their Patient Care Accounts
- The PCP makes the two most important decisions in the whole health care system:
  - When to refer
  - To whom to refer
- They do so with no stake in the downstream cost of their decisions

The Real-Life Impact of Referral Decisions

Member Requires Hip or Knee Replacement



The decision of the PCP for one member for one procedure can have a $20,000 impact

Source: CareFirst Health Care Analytics, Data as of September 2010

Sample Patient Care Account – One Patient

Mary Smith

One Patient Thru September

- Debits (Care Expenses)			+ Credits *		
Debit: Mary Smith			Credits: Mary Smith		
Primary Care Visit 1/4/10	$	50			
Vaccination 1/4/10	$	4	Credits: Mary Smith		
Pharmacy Fill 1/7/10	$	120	January	$	210
ER Visit 2/4/10	$	125	February	$	210
ER Treatment 2/4/10	$	300	March	$	210
Ophthalmologist Specialist Visit 3/6/10	$	127	April	$	210
Orthopedic Specialist Visit 4/22/10	$	257	May	$	210
Pharmacy Fill 4/10/10	$	120	June	$	210
Physical Therapy 4/25/10	$	22	July	$	210
Physical Therapy 5/5/10	$	22	August	$	210
Pharmacy Fill 7/10/10	$	120	September	$	210
Primary Care Visit 8/4/10	$	50	October	$	210
Dermatologist Specialist Visit 8/22/10	$	300	November	$	210
Pathology Test 8/23/10	$	50	December	$	210
Dermatologist Specialist Visit 9/12/10	$	100			
Cardiology Specialist Visit 9/22/10	$	554			
Outpatient Hospital Bill 10/15/10	$	1,325			

Total Debits: $3,646

Total Credits: $2,520

Measuring Quality of Care

Degree of Engagement	Appropriateness of Use	Effectiveness of Care	Patient Access	Structural Capabilities
30 Points	20 Points	20 Points	20 Points	10 Points

Possible Points	Engagement Metric
4.5	Schedule Appointments
12.0	Patients Receive Appointments
4.5	Care Plan Clear
4.5	Care Coordination Accomplished
4.5	Active Follow-ups

Sample of the PCMH Composite Quality Score Card

- The Score Card shows the quality measures that the CareFirst PCMH program uses to compute a Panel's Quality Score.
- The measurements include claims-based and non-claims-based measures and list achievable points by measure.

		Points	Metrics	PCMH
PCP Engagement		4.5	Schedule Appointments	3.7
		12.0	Patients Receive Appointments	10.1
		4.5	Care Plan Clear	4.1
		4.5	Care Coordination Accomplished	4.0
		4.5	Active Follow-ups	4.0
		30.0	Engagement Composite	25.9
Appropriate Use of Services	Admissions	8.0	Preventable Admissions (AHRQ)	2.3
			Potentially Preventable Readmissions	2.0
			Rate of Use of Specialty Medical Home	1.5
			Admissions Composite	5.8
	Potentially Avoidable ER	4.0	Potentially Preventable Emergency Room Use	2.9
	Ambulatory Diagnostic, Imaging, and Antibiotics	8.0	Colonoscopy	1.1
			CT Scans	1.3
			MRI	1.0
			Patients with Low Back Pain (HEDIS)	0.7
			Patients with Viral Upper Respiratory Infections	1.2
			Patients with Pharyngitis	0.9
			Diagnostic, Imaging, and Antibiotics Composite	9.1
Effectiveness of Care	Chronic Care Maintenance	10.0	Diabetes	1.8
			Asthma	0.7
			Congestive Heart Failure	1.7
			Coronary Artery Disease	1.4
			Coronary Artery Disease - Myocardial Infarction	1.6
			Major Depressive Disorder	0.8
			Chronic Care Maintenance Composite	8.0
	Population Health Measures	10.0	Colon Cancer Screening	1.6
			Chlamydia Screening	1.0
			Cervical Cancer Screening	1.3
			Breast Cancer Screening	1.3
			Childhood Immunizations	1.7
			Population Health Maintenance Composite	6.9
Access		5.0	Use of E-Scheduling	2.5
		5.0	Use of E-Visits	2.0
		5.0	Extended Office Hours	4
		5.0	Patient Office Experience, such as Wait Times	3
		20.0	Access Composite	11.5
Structure		2.5	Use of E-Prescribing	2.2
		2.5	Electronic Medical Records Meaningful Use	2.5
		2.5	Use of Email	1.0
		2.5	External Certification	2.5
		10.0	Structure Composite	8.2
		100.0	**Overall Practice Composite**	**78.3**

The Outcome Incentive Award

- Award is based on each Panel's overall performance – on quality and cost for whole patient populations
- Degree of savings and degree of quality attainment intersect on grid
- The higher the point of intersection, the greater the reward – expressed in fee supplement shown (i.e. 60 quality points at 6% savings equals a supplemental fee of 34% for the following year to the PCP's in the Panel
- Multi-year performance at high levels increases fee supplement – rewarding consistent performance over an extended period of time

Outcome Incentive Award for a Panel with 3,000 Members

PCP PERCENTAGE POINT FEE INCREASE: YEAR 1					
QUALITY SCORE	SAVINGS LEVELS				
	10%	8%	6%	4%	2%
80	67	53	40	27	13
60	56	45	34	23	11
40	46	37	28	18	9
20	36	29	22	14	7

PCP PERCENTAGE POINT FEE INCREASE: YEAR 2					
QUALITY SCORE	SAVINGS LEVELS				
	10%	8%	6%	4%	2%
80	77	61	46	31	15
60	65	52	39	26	13
40	53	42	32	21	11
20	41	33	25	16	8

PCP PERCENTAGE POINT FEE INCREASE: YEAR 3					
QUALITY SCORE	SAVINGS LEVELS				
	10%	8%	6%	4%	2%
80	90	72	54	36	18
60	76	61	46	30	15
40	62	50	37	25	12
20	48	39	29	19	10

Has this model proven effective in attracting practitioners?

Profile of PCP Practices in CareFirst Networks

PCP Practice Size	# of PCP's	% in PCMH Program	# in PCP Program	% of All PCP's
1 - 2 Physicians	1,745	59%	1,030	39%
3 - 4 Physicians	525	62%	326	12%
5 - 9 Physicians	620	76%	471	14%
10 - 15 Physicians	316	90%	287	7%
16 + Physicians	632	88%	556	14%
Physicians in Large Health Systems*	592	68%	403	13%
	4,430	71%	3076	100%

- ** Large Health Systems = UPI, MEDSTAR, Maryland Primary Care, LIFEBRIDGE, Johns Hopkins Community Physicians, GBMC, and Fairfax Family Practice.*
- *NOTE - MPP Practitioners not yet excluded (239 PCP's).*
- *RPN includes 5,200 primaries but once ineligible primaries are eliminated, the denominator is 4,430 primaries*

Source: CareFirst internal data. Information current as of August 1, 2011.

CareFirst Now Has One of the Largest PCMH Networks in the U.S.

- Over 3,000 PCP's in approximately 275 Medical Care Panels – includes 265 Nurse Practitioners
- Nearly half are composed of 1-4 PCP practices
- Nearly 90 percent are independent – not employed by large health systems
- Two thirds of all PCP's in the region are in the Program – and growing
- All 2.6 million of local CareFirst members are in the Program except if they opt out (rare)
- Program accommodates all forms of benefit designs, products (PPO, HMO, CDH)
- Coverage throughout the region (Maryland, DC, Northern Virginia)
- All employer groups, individual coverage, risk arrangements included (Full premium, ASO)

Practitioner Payment Innovation in Other Areas

- Oncology Pathways Program (Pay for Performance)
  - Oncologists Enroll Voluntarily
  - Paid More for Adherence to Evidence-based Medicine
  - Drives Better Clinical Outcomes
  - Drives Substantial Improvements in Symptom Management
  - Results in Lower Admission Rates and ER Use
  - Launched August 2008, Now in Third Generation
- Medication Management Services (Investing Where it Counts)
  - Now Paying Pharmacists for Active Role in Medication Management
  - Focus on Chronically Ill Members on Multiple Medications
  - Better Medication Adherence = Better Outcomes + Lower Cost
  - Launched for Pharmacy Benefit Members September 1, 2011

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PCMH
Primary Care Medical Home

Reference Slides for Q&A Follow

Lessons Learned in Three-Year CareFirst PCMH Pilot (2008 – 2010)

- Focused on willing, able, and ready PCP practices, ranging in size from 5 – 15 PCPs – Average size: 10 physicians
- Intensively helped them upgrade to higher level of NCQA certification with great success
    - 9 of 11 practices made it to NCQA PPC PCMH Certification Level 3
- Put in new EMR/PM systems and paid for them in a number of cases
- Supported and paid for transformation – via Transformed
- Paid $4 PMPM to assist with resources necessary to a max of $100,000 per year per practice
- In total, spent nearly $5 million in support resources for these practices
- **Some success, but never got to the point where the practices were focused on care management via care plans**

Key Insights from CareFirst Pilot

- Not effective to focus only on what happens in PCP office alone

- It's not about EMRs, although they are helpful – it is about:
  - interconnectivity with the rest of the health care system and enhanced coordination across settings
  - consolidated view of all care around a single patient
  - Upgrade to higher NCQA certification level alone does not mean much

- Change in health care financial incentives is critically important – without this, nothing much happens
- Huge augmentation in PCP practice capabilities needed – particularly nursing support of care plan process
- Accountability: Scope of what a PCP is accountable for matters a lot – needs to be more than what goes on in their office

Missing Elements in Current System

- No systematic detection of multiple chronic disease patients or those at high risk for these diseases
- No or inadequate nursing support to set up care plans and track patients across care settings and time
- No complete record of the patients' experience and services across care settings
- No detection and support during admission and discharge from the hospital
- No or inadequate patient maintenance at home – especially for psycho-social needs and medication therapy management and related aide services or monitoring

Fee for Service – Necessary and Even Useful

- All agree it needs to be checked – leads to “inflation” in volume of services
- However, fee for service captures with increasing detail the scope and nature of services rendered across all settings (ICD-10/5010)
- It supports the ASO business – now at least half of all enrollment
- It ties reimbursement to service – causing discipline, timeliness and accuracy
- It is the only short / intermediate-term route to large scale adoption of financial incentive changes
- Challenge is to hold it in check, not abandon it – global capitation targets can be established with PCP’s who remain on fee for service

Key Elements of CareFirst's PCMH Design

- PCP's are in no position to take risk
- Program is not about just primary care – it is about all care in all settings under guidance of the PCP
- PCP's are organized into small panels – big enough to see patterns, small enough to keep accountable and directly tie incentives to results
- Blend of capitation and fee for service – no risk shift – all incentive based
- A "Patient Care Account" is set up for each panel – a score-keeping system
- Capitation is much like setting a premium rate – based on global claims history of patients in each panel trended to "performance year"
- Fee for service is the basic score-keeping method during the course of each calendar year
- Outcome incentives are based on overall results: Was global capitation bettered? Was quality strong?
- Greater focus on chronic disease patient and those at high risk for chronic these
- **Conclusion: Powerful change in health care incentives is needed, but a wholesale abandonment of fee for service is not wise**

Needed Elements – No One Silver Bullet

- Online master Member Health Record
- Single care plan across all care settings with dedicated nursing support in the community at the heart of a community-based team
- Special provision for coordinated home-based services that are not just clinical
- Online ability in real time to see data by episode for each patient and all patient cohorts
- Nursing presence in hospitals to track admissions, select the most intense patients, and coordinate care post discharge
- Incentives to PCP's to pay attention to care patterns, referral choices, and overall outcomes

Program Introduces Key Changes in Reimbursement for PCP's

- Reimbursement incentives are key to reform
- Blend of global capitation and fee for service – very scalable
  - Global capitation is total expected cost of care for each member
  - Fee for service is based on current CareFirst allowed payment levels
- No shift of risk – all incentive based – PCP's not in position to accept substantial risk
- Three components to incentives:
  - Up front fee increase (12%) to join and accept responsibilities in Program
  - Payment for setting up and monitoring care plans
  - Gain share (approximately 30 percent of global savings) based on outcomes (quality and cost combined)

Basic Building Block is the Small Performance Unit: Medical Care Panels

- Composed of PCP's and or Nurse Practitioners
- Size range accepted: 5-15 PCP's; average of 10 PCP's
- Three functions:
  - back up and coverage
  - peer group review
  - pooled experience to see patterns
- Can be "virtual" or part of larger, existing group practice
- Geographically concentrated and contiguous
- Generally like with like (internal medicine, family practice, etc)
- Special effort to bring in FQHC's – CareFirst grants to help them form functional equivalents to Panels
  - 228 community health centers in the region serving 626,000 residents
  - 168 of these health centers are FQHC's
- Panels are anti monopolistic in their structure, design and intent – to counter the congealing of large systems

PCP's Have Global Accountability for Cost, Quality – Total Outcomes

- PCP's are responsible for all care of their whole patient population – not just primary care
    - PCP's share of total cost is 5.5 percent of total medical care cost
    - Decisions on when and where to refer drive everything that follows
- Global budget targets are based on trended/ risk adjusted historical total cost for each Panel's patient population ("Credits" in Patient Care Account maintained by CareFirst for each Panel)
- Drug, behavioral health, ancillaries, and all other medical costs are included – all costs are accounted for down to every line on every claim ("Debits" in Patient Care Account)
- Patient Care Account creates a running detailed record of Panel performance down to PCP and patient specific level on all services on all services
- Comprehensive data for claims enables episode tracking and quality measures to be readily calculated

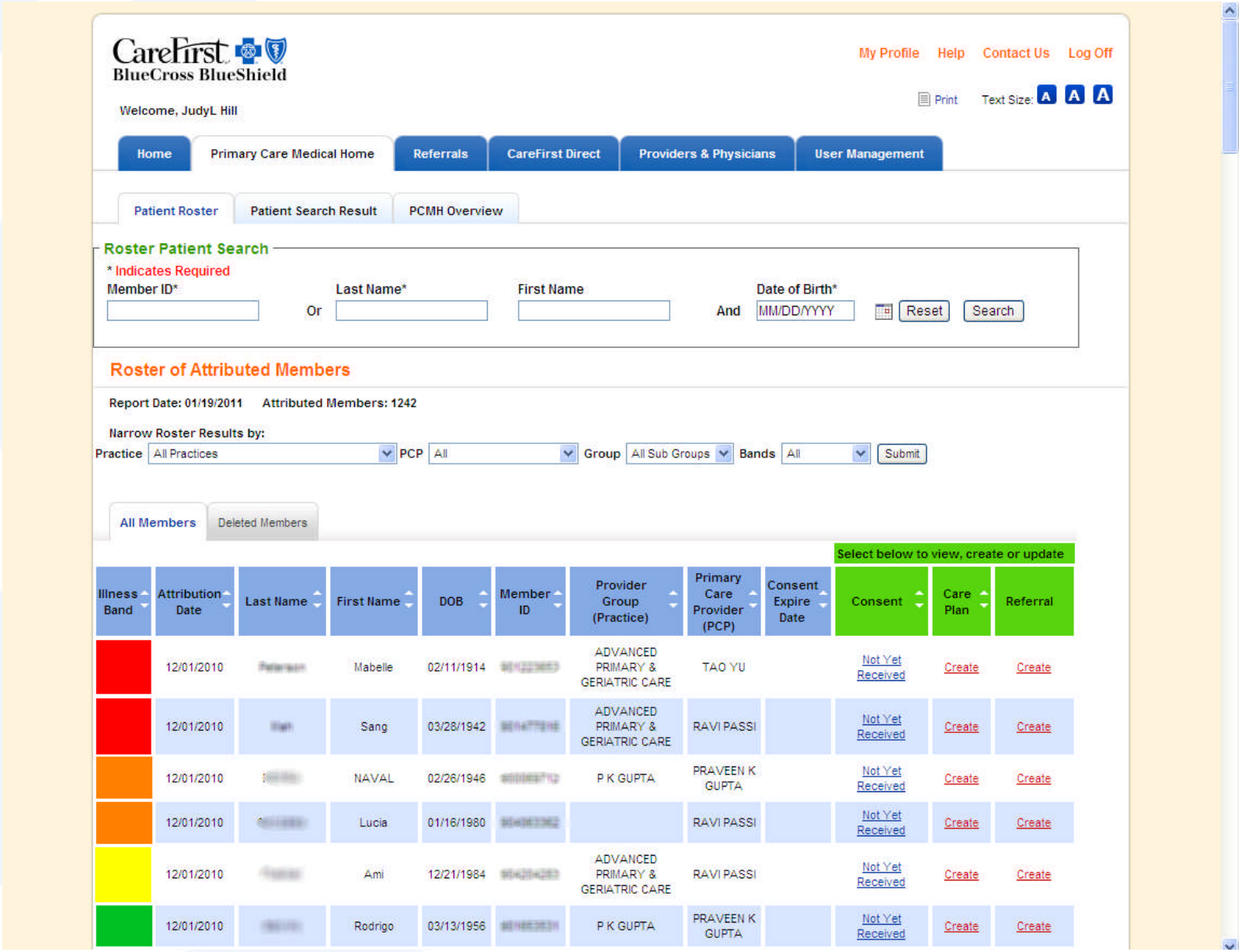
Panel Patient Membership is Determined through Attribution

- Patient attribution to each PCP is based on patient actual use of a PCP's services for primary care
- Total patients attributed to each PCP are summed for panel as a whole
- Total patient population of each panel is stratified by illness burden score (DxCG). This creates illness / wellness pyramid for each panel.
- Illness Burden score is calculated monthly – used to risk adjust global budget targets
- Patient population stratification is key to focusing PCP attention on those patients with multiple chronic diseases or at high risk for these diseases as well as keeping those that are healthy well

Typical Primary Care Practice

- 2,500 active patients per physician (average – includes all payers)
- 10 physicians per panel equates to 25,000 patients (all payers)
- Based on CareFirst market share in our region, 2,000 – 4,000 of these patients in an average panel are likely to be CareFirst members
- 3,000 members generate $12 - $15 million per year in health care costs and 60,000 - 70,000 encounters annually
- The Illness / Wellness pyramid with its band distribution is made available to each panel/practice within each panel

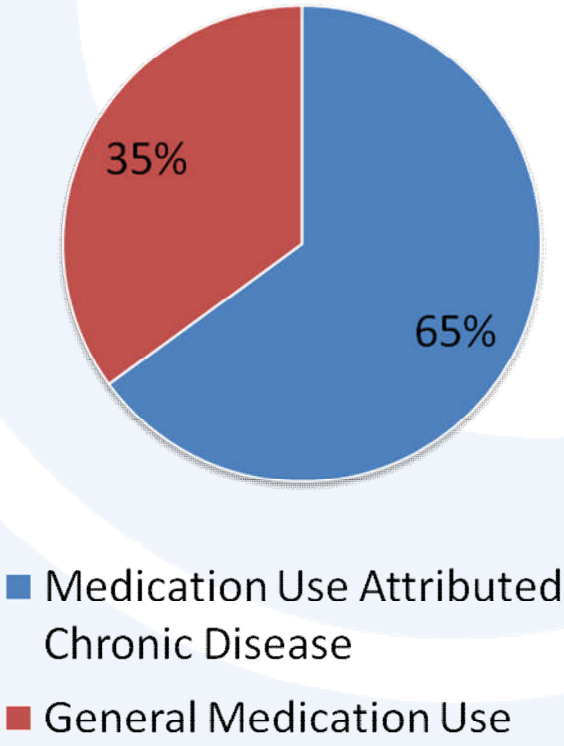
Attributed Member Roster View



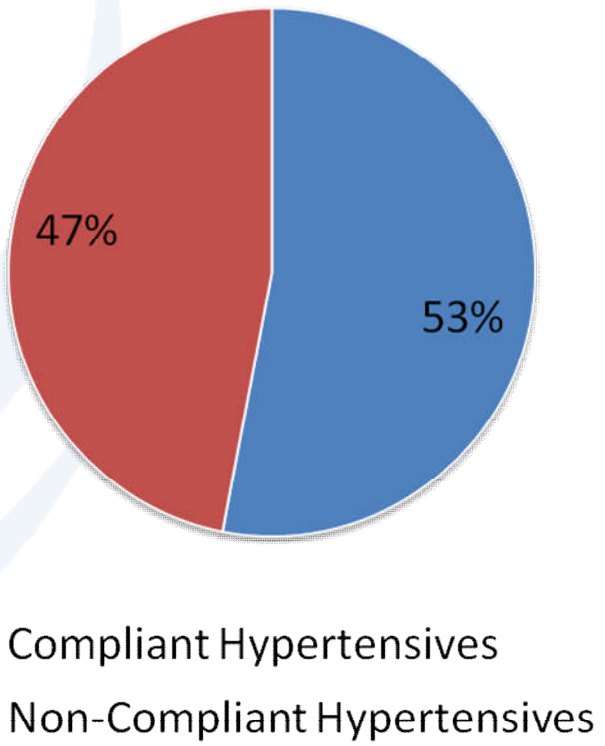
Medication Management Services

- New studies demonstrate the impact of compliance with prescribed medication therapy on overall medical costs.[1]

A Majority of Spending on Pharmaceuticals is for the Management of Chronic Disease



CareFirst Members Non-Compliant with Hypertensive Medication Therapy Generate 31% Higher Medical Cost[2]



1. *Health Affairs, 30, no.1 (2011):91-99;* 2. *CareFirst Data for Members with Medical AND Pharmacy Benefit*

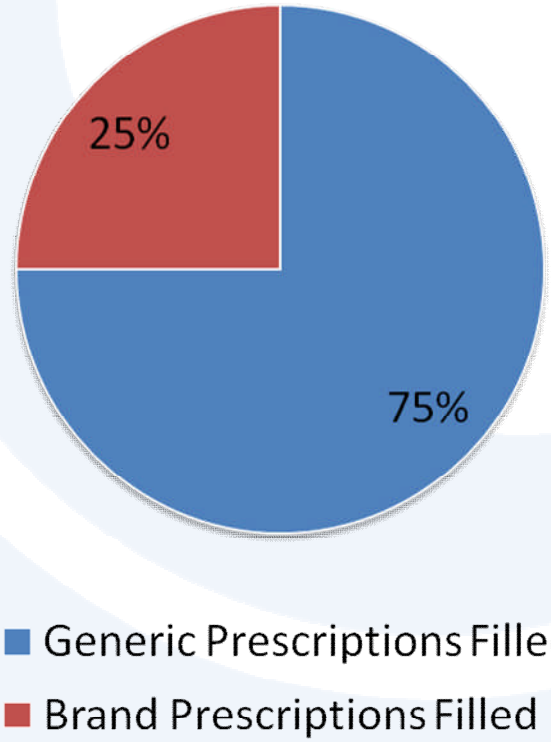
Medication Management Services Program

- CareFirst will support the efforts of the primary care provider by providing a Medication Management Services program to the prescription benefit population
- The foundation of the Medication Management Services program are patient consultation services provided by their primary pharmacist
- Interventions can be initiated by the patient, pharmacist, or from results of data analysis efforts
- This program has been proven successful in our Part D benefit and is being expanded to our entire population with pharmacy benefits effective this month

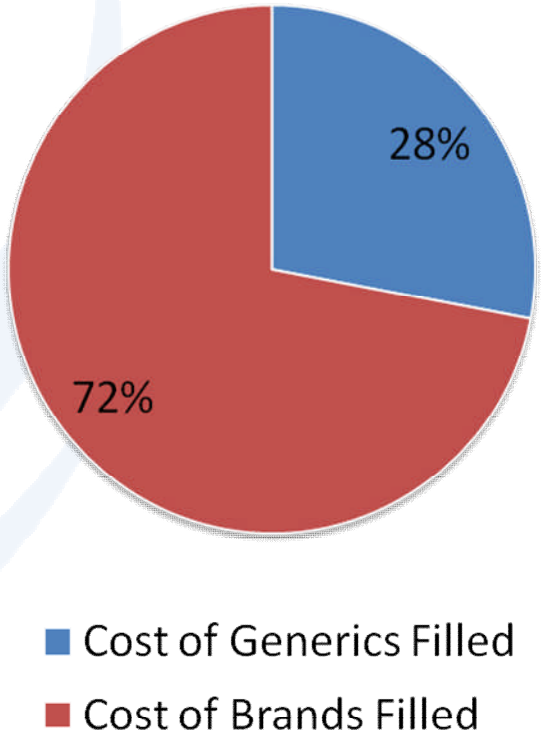
The Value of Medication Management

- The Cost of Generic vs. Brand Medications

Generic vs. Brand In Quantity of Prescriptions Filled



Generic vs. Brand in Total Cost



Source: CareFirst Internal Data

Extensive Infrastructure Support Provided by CareFirst

- Case Management and Hospital Transition Coordinators for Bands 1 and 2
- Care Plans through locally based nurse coordinators for those in Bands 2 and 3 – under oversight of Regional Care Coordinators (specially trained nurses)
- Comprehensive care plans track services for band 1 – 3 patients over time in all care settings over the web
- Tracking of referral patterns in and out of network is automatic over the web
- Full data profiling by patient, PCP and panel – episode based – costs shown – choice of specialist supported by data
- Single Member Health Record across all care settings – organized by episodes of care (MEG's) – available 24/7 over the web
- Reporting / risk identification services / risk management consulting support is ongoing

Analytics and Feedback is Central Area of Focus

- SearchLight is an advanced reporting system which combines sophisticated queries developed at CareFirst with industry standard reports to detect gaps in care
- Rapid identification of risks – those likely to move between illness bands
- Polypharmacy analysis
- Detection of patterns/clusters /multiple chronic diseases
- Geo-mapping supports identification of patient care use patterns
- PCP peer benchmarking data

Understanding Patterns – Zoom In and Out – Like Google Earth for Healthcare

Dominant Episodes in Practice → All Members with Selected Dominant Episodes → Individual Member Selected within Dominant Episode Family

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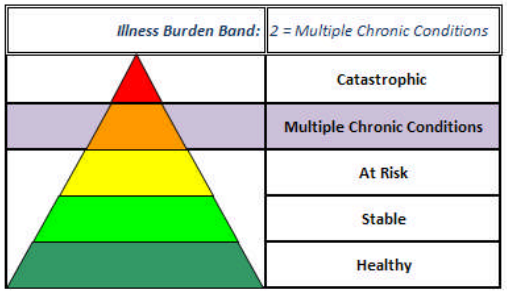
PCMH - Patient Care Accounts

PCMH Primary Care Medical Home

Medical Panel - MP11100057



Patient Care Accounts by Dominant Episode

#	Dominant Episode	Patients	Dominant Episode $	Total Patient $	% of Total Debit $
1	Osteoarthritis	101	$589,644	$876,331	10.9%
2	Diabetes	54	$275,921	$457,141	5.7%
3	Mental Hlth - Bipolar Disorder	16	$197,655	$305,063	3.8%
4	Hypertension, Essential	72	$136,637	$287,714	3.6%
5	Pregnancy w Cesarean Section	14	$204,953	$248,989	3.1%
6	Cerebrovascular Disease	19	$154,911	$228,958	2.8%
7	Coronary Artery Disease	33	$119,969	$210,317	2.6%
8	Spinal/Back Disorders, Lower Back	32	$127,691	$195,746	2.4%
9	Multiple Sclerosis	3	$165,814	$170,907	2.1%
10	Infec/Inflam - Skin/Subcu Tiss	27	$105,456	$170,465	2.1%
11	Pregnancy w Vaginal Delivery	13	$136,285	$158,822	2.0%
12	Cancer - Breast	14	$92,501	$154,943	1.9%
13	Rheumatoid Arthritis	10	$126,210	$143,991	1.8%
14	Cholecystitis/Cholelithiasis	10	$107,228	$124,196	1.5%
15	Hernia/Reflux Esophagitis	18	$59,556	$122,388	1.5%
16	Tumors - Gynecological, Benign	9	$94,065	$121,932	1.5%
17	Eye Disorders, Degenerative	29	$69,791	$117,973	1.5%
18	HIV Infection	3	$75,907	$105,610	1.3%
19	Cancer - Renal/Urinary	7	$66,510	$104,318	1.3%
20	Arthropathies/Joint Disord NEC	30	$40,574	$101,958	1.3%
21	Bursitis	12	$49,754	$90,062	1.1%
22	Neurological Disorders, NEC	17	$48,909	$86,343	1.1%
23	Spinal/Back Disorders, Excl. Low	13	$52,190	$83,163	1.0%
24	Asthma	11	$39,792	$81,049	1.0%
Episodes above 1% of Total Debits		567	$3,137,922	$4,748,381	59.0%
Episodes below 1% of Total Debits		483	$1,494,322	$2,556,759	31.0%
Other Non-Grouped Debits				$804,388	10.0%
Total		**1,050**	**$4,632,244**	**$8,043,876**	**100.0%**

Zoom Feature – "Google Earth" of Patterns Within and Across Panels

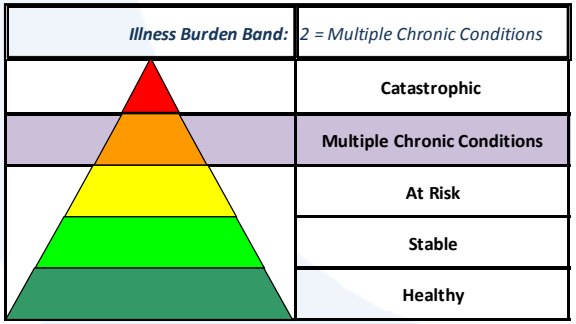
Dominant Episodes in Practice → All Members with Selected Dominant Episodes → Individual Member Selected within Dominant Episode Family

CareFirst BlueCross BlueShield

PCMH - Patient Care Accounts

PCMH Primary Care Medical Home

Medical Panel - MP11100057



Patient Care Accounts by Patient

Patients with Dominant Episode - Diabetes

#	Last Name	First name	Member ID	DOB	Total Debit $
1	Ewing	Patrick	234234234	1/21/1949	$66,399
2	Doe	John	655654654	10/5/1953	$43,553
3	**********	**********	**********	**********	$37,554
4	**********	**********	**********	**********	$36,278
5	Jackson	Karen	655654657	10/8/1953	$27,412
6	**********	**********	**********	**********	$25,203
7	Tripper	Tina	655654659	10/10/1946	$19,577
8	Wade	Dwayne	655654660	10/11/1983	$16,772
9	Jones	Bob	655654661	10/12/1967	$16,724
10	**********	**********	**********	**********	$16,324
11	**********	**********	**********	**********	$15,146
12	Jordan	Michael	655654664	10/15/1997	$13,567
13	**********	**********	**********	**********	$11,550
14	Brady	Tom	655654666	8/17/1952	$10,869
15	Mays	Gordon	655654667	10/18/1953	$10,799
46	Richards	Larry	655654670	10/21/1922	$2,390
47	Hughes	Felix	655654671	10/22/1999	$1,983
48	Doe	Jane	655654672	10/23/2001	$1,376
49	**********	**********	**********	**********	$1,292
50	Wall	John	655654674	10/25/2008	$1,143
51	**********	**********	**********	**********	$966
52	James	Lebron	655654676	10/27/1948	$965
53	Newman	Jack	655654677	10/28/1957	$686
54	**********	**********	**********	**********	$425
Total		**54**			**$457,141**

Member Name: John Doe DOB: 02/20/1964 **Age:** 47 **Gender:** Male **Ethnicity:** African American **Member ID:** 820020302

Practice: Maryland Family Care **PCP:** Dr. Sirkis **Panel:** MP11100123 **Print**

Care Plan Status: In Progress **Started:** 01/17/2011 **Updated:** 05/31/2011 **Consent:** Yes (1/31/2011) **Chronicity:** Chronic

Member Health Record

- MHR Timeline
- MHR Details

Feb 2010 – Jan 2011

Episodes	% of Total $	Jan 11	Dec 10	Nov 10	Oct 10	Sep 10	Aug 10	Jul 10	Jun 10	May 10	Apr 10	Mar 10	Feb 10
Diabetes	70%	1			3			1			2		1
Coronary Artery Disease	13%					1					1		1
Cancer – Skin	5%				1								
Neoplasm, Benign: Sinuses	4%						2				1		
Tumors - Gastroint, Benign	4%										1		
Non-Episode Related	4%								2				

Shading indicates Episode Duration. Count Indicates Number of Services during the period.

Number of Services by Month

Service Types	% of Total $	Jan 11	Dec 10	Nov 10	Oct 10	Sep 10	Aug 10	Jul 10	Jun 10	May 10	Apr 10	Mar 10	Feb 10
Inpatient Hospital	16%	1											
Emergency Room	14%							1					1
Outpatient Facility	22%												
Urgent Care Facility	4%										1		
Office, Specialist	10%				2	1							
Office, PCP	5%												1
Outpatient Imaging / Radiology	14%				2						1		
Laboratory	10%						2				3		
Other	5%								2				

Count Indicates Number of Services during the period.

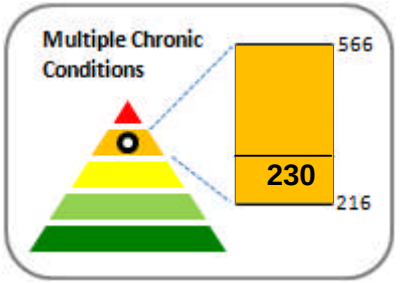
Prescription Drugs

Drug Name	Therapeutic Class	Jan 11	Dec 10	Nov 10	Oct 10	Sep 10	Aug 10	Jul 10	Jun 10	May 10	Apr 10	Mar 10	Feb 10
Amoxicillin	Antibiot, Penicillins					10d							
Avandia	Antidiabetic Agents, Misc				90d								90d
Lipitor	Antihyperlipidemic Drugs, NEC		90d					90d					
Tricor	Antihyperlipidemic Drugs, NEC				90d						90d		
Ramipril	Cardiac, ACE Inhibitors						90d				90d		

Products are grouped and color coded by Therapeutic Class. Click to see more details.

Member Since: March 2009

John Doe's Illness Score



Health Care Dollars

Trailing 12 Months: $17,967

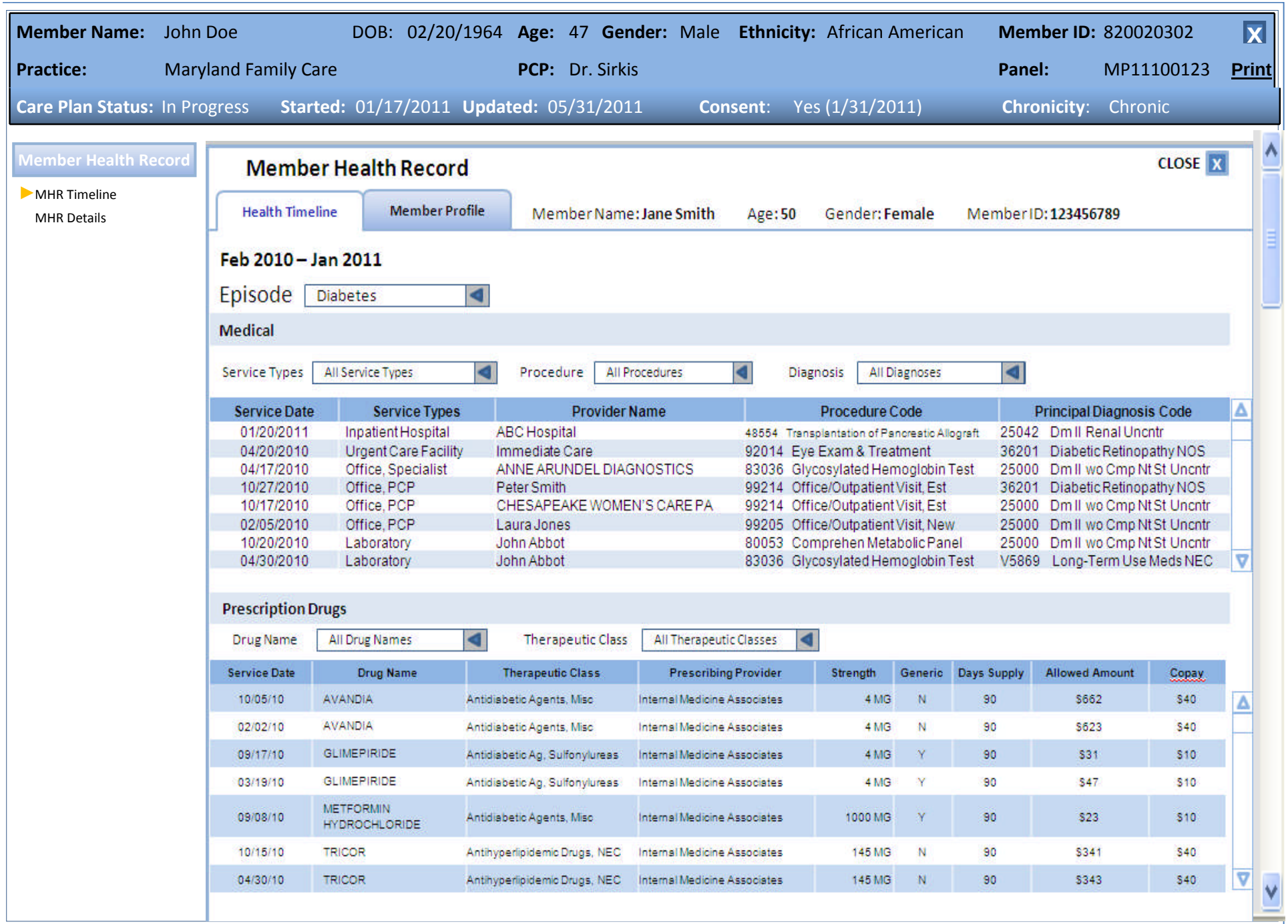
Year to Date : $15,136

(YTD has 3 month lag for claims run out)

Care Plan: **Yes**

Member Alert History

Date	Type	Facility
1/1/11	Hospital Admission	ABC Hospital
7/4/10	ER Admission	XYZ Hospital
9/25/09	ER Admission	XYZ Hospital
9/10/09	ER Admission	XYZ Hospital


Member Name: John Doe DOB: 02/20/1964 Age: 47 Gender: Male Ethnicity: African American Member ID: 820020302
Practice: Maryland Family Care PCP: Dr. Sirkis Panel: MP11100123 Print
Care Plan Status: In Progress Started: 01/17/2011 Updated: 05/31/2011 Consent: Yes (1/31/2011) Chronicity: Chronic
Member Health Record
MHR Timeline
MHR Details
Member Health Record
CLOSE
Health Timeline
Member Profile
Member Name: Jane Smith Age: 50 Gender: Female Member ID: 123456789
Feb 2010 – Jan 2011
Episode Diabetes
Medical
Service Types All Service Types Procedure All Procedures Diagnosis All Diagnoses
Service Date | Service Types | Provider Name | Procedure Code | Principal Diagnosis Code
01/20/2011 | Inpatient Hospital | ABC Hospital | 48554 Transplantation of Pancreatic Allograft | 25042 Dm II Renal Uncntr
04/20/2010 | Urgent Care Facility | Immediate Care | 92014 Eye Exam & Treatment | 36201 Diabetic Retinopathy NOS
04/17/2010 | Office, Specialist | ANNE ARUNDEL DIAGNOSTICS | 83036 Glycosylated Hemoglobin Test | 25000 Dm II wo Cmp Nt St Uncntr
10/27/2010 | Office, PCP | Peter Smith | 99214 Office/Outpatient Visit, Est | 36201 Diabetic Retinopathy NOS
10/17/2010 | Office, PCP | CHESAPEAKE WOMEN'S CARE PA | 99214 Office/Outpatient Visit, Est | 25000 Dm II wo Cmp Nt St Uncntr
02/05/2010 | Office, PCP | Laura Jones | 99205 Office/Outpatient Visit, New | 25000 Dm II wo Cmp Nt St Uncntr
10/20/2010 | Laboratory | John Abbot | 80053 Comprehen Metabolic Panel | 25000 Dm II wo Cmp Nt St Uncntr
04/30/2010 | Laboratory | John Abbot | 83036 Glycosylated Hemoglobin Test | V5869 Long-Term Use Meds NEC
Prescription Drugs
Drug Name All Drug Names Therapeutic Class All Therapeutic Classes
Service Date | Drug Name | Therapeutic Class | Prescribing Provider | Strength | Generic | Days Supply | Allowed Amount | Copay
10/05/10 | AVANDIA | Antidiabetic Agents, Misc | Internal Medicine Associates | 4 MG | N | 90 | $662 | $40
02/02/10 | AVANDIA | Antidiabetic Agents, Misc | Internal Medicine Associates | 4 MG | N | 90 | $623 | $40
09/17/10 | GLIMEPIRIDE | Antidiabetic Ag, Sulfonylureas | Internal Medicine Associates | 4 MG | Y | 90 | $31 | $10
03/19/10 | GLIMEPIRIDE | Antidiabetic Ag, Sulfonylureas | Internal Medicine Associates | 4 MG | Y | 90 | $47 | $10
09/08/10 | METFORMIN HYDROCHLORIDE | Antidiabetic Agents, Misc | Internal Medicine Associates | 1000 MG | Y | 90 | $23 | $10
10/15/10 | TRICOR | Antihyperlipidemic Drugs, NEC | Internal Medicine Associates | 145 MG | N | 90 | $341 | $40
04/30/10 | TRICOR | Antihyperlipidemic Drugs, NEC | Internal Medicine Associates | 145 MG | N | 90 | $343 | $40

New Reimbursement Categories Established to Support PCMH Program

- Fee supplement to participating PCP's (12%)
- Added reimbursement codes and rates for PCP's to create a care plan or maintain one ($200 + $100)
- Global fee for care plan support and maintenance by local nurse
- Global fee for coordinated package of home based services
- All these new reimbursements are treated as "debits" to the Patient Care Account

In Summary – The Essential "Ingredients" of CareFirst PCMH Program

1. Global PCP financial accountability without risk but powerful incentives for overall quality and cost outcomes
2. Local Care Coordinator support – comprehensive care plans
3. Nurse presence in hospitals connected to case management
4. One Member Health Record with care plan embedded
5. SearchLight reporting capability

Measuring Quality of Care

Degree of Engagement	Appropriateness of Use	Effectiveness of Care	Patient Access	Structural Capabilities
30 Points	20 Points	20 Points	20 Points	10 Points

Possible Points	Appropriateness Metric
8.0	Admissions: Preventable Admissions (ARHQ), Potentially Preventable Readmissions, Rate of Use of Specialty Medical Home, Admissions Composite
4.0	Potentially Preventable Emergency Room Use
8.0	Ambulatory, Diagnostic, Imaging and Antibiotics

Measuring Quality of Care

Degree of Engagement	Appropriateness of Use	Effectiveness of Care	Patient Access	Structural Capabilities
30 Points	20 Points	20 Points	20 Points	10 Points

Possible Points	Effectiveness Metric
10.0	Chronic Care Maintenance (Diabetes, Asthma, CHF, CAD, MI, Depression)
10.0	Population Health Measures (Screenings, Immunizations)

Measuring Quality of Care

Degree of Engagement	Appropriateness of Use	Effectiveness of Care	Patient Access	Structural Capabilities
30 Points	20 Points	20 Points	20 Points	10 Points

Possible Points	Access Metric
5.0	Use of E-Scheduling
5.0	Use of E-Visits
5.0	Extended Office Hours
5.0	Patient Office Experience (e.g. Wait Times)

Measuring Quality of Care

Degree of Engagement	Appropriateness of Use	Effectiveness of Care	Patient Access	Structural Capabilities
30 Points	20 Points	20 Points	20 Points	10 Points

Possible Points	Structural Metric
2.5	Use of e-Prescribing
2.5	Electronic Medical Records Meaningful Use
2.5	Use of E-mail
2.5	External Certification

CareFirst BlueCross BlueShield

PCMH
Primary Care Medical Home

A Sample PCMH Care Plan Follows this Slide

Member Care Plan

Print

John Doe (8200203)
DOB: 12/05/1945
65, Male
Caucasian

Practice: Maryland Family Care
PCP: Dr. Robert Miller
Panel: MP11100123
Consent: Yes (exp. 1/31/2012)

Responsible Lead: Mary Smith LCC
Care Plan Status: In Progress
Started: 01/17/2011
Last Updated: 06/02/2011

Current Problem List:
- Diabetes
- Renal/Urinary Disord, NEC
- Coronary Artery Disease

Clinical Summary
- Patient Narrative
- Past Health History
- Social History
- Family History
- Medications
- Diagnostics/Lab Results
- Vital Signs
- Guideline Evaluation

Encounter History
Assessment and Plan
Home Based Care
Care Coordination
Member Health Record

Quick Links
- Add Encounter
- Add Assessment
- Add Action

Patient Narrative

Last Updated: 06-17-2011 By: Mary Smith LCC

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Updated
6/17/11
6/02/11
5/12/11
5/01/11
3/31/11
1/10/11

This is a 65 year old English speaking Caucasian male. He is divorced with 2 children. He lives alone in a condominium and is currently self employed running his own consulting business. He has worked as a Hospital Administrator in New York for most of his career. Minimal family history is known. He was a pack a day smoker however he quit smoking in 1985. He reports he rarely uses alcohol.

Since 2009 he has struggled with Diabetes type II and currently has an elevated HgA1c of 10.4. He is being followed by Dr. Cantero, Endocrinologist. He originally was managed on Metformin, but due to an alarming increase in creatinine level, he is currently insulin dependent. He is checking his blood sugar five times a day and reporting this daily to his Endocrinologist by e-mail. He would like to decrease this task. He is prescribed an 1800 calorie ADA low salt, low cholesterol diet. He is currently attending sessions with a diabetic educator at the endocrinologist office.

He also suffers with Coronary Artery Disease, with previous four vessel coronary artery by-pass surgery in 2004. His last EKG revealed normal sinus rhythm without ectopy. He is being followed by Dr. Jacobs, Cardiologist. Recent lipid profile reveals normal LDL, HDL, Triglycerides and total cholesterol. He exercises daily by walking every night for 20 to 30 minutes. He is unable to do a lot of aerobic exercise due to a spinal fusion in 2005. He follows his medication plan and is taking daily aspirin and vitamins. His blood pressure had been stable until March 2011 when he was hospitalized for hypotension, dehydration and uncontrolled diabetes. Due to hypotension, his ACE inhibitor was placed on hold at the time of discharge to be reevaluated by his Cardiologist.

Recent kidney function tests are borderline with documented glomerular sclerosis. Current lab work revealed elevated serum creatinine at 1.51mg/dl; BUN elevated level 32mg/dl, and low glomerular filtration rate of 48 ml/min. The low glomerular filtration rate has persisted for greater than three months with an elevated urine protein. PCP feels this may be indicative of chronic kidney disease related to diabetes and he has been referred to a Nephrologist. He has an appointment scheduled on June 28, 2011.

He appears his age, without distress. He is mildly obese and his has lost 20 lbs in the last 4 months. He has a history of depression with anxiety which is stable with current medication regimen. The PCP and patient both expressed that his depression has much improved over the past 4 yrs but agree that the struggle with diabetes stabilization is a stressor.

Member Care Plan

Print

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Past Health History

Last Updated: 06-17-2011 By: Mary Smith LCC

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Updated
6/17/11
6/02/11
5/12/11
5/01/11
3/31/11
1/10/11

- **Diabetes** (Active)

Since 2009 he has struggled with Diabetes type II and currently has an elevated HgA1c of 10.4. He originally was managed on Metformin, but due to an alarming increase in creatinine level, he is currently insulin dependent.

- **Glomerular Sclerosis** (Active - New Onset)

Recent kidney function tests are borderline with documented glomerular sclerosis. Current lab work revealed elevated serum creatinine at 1.51mg/dl; BUN elevated level 32mg/dl, and low glomerular filtration rate of 48 ml/min. The low glomerular filtration rate has persisted for greater than three months with an elevated urine protein.

- **Coronary Artery Disease** (Active)

Previous four vessel coronary artery by-pass surgery in 2004. His last EKG revealed normal sinus rhythm without ectopy. Recent lipid profile reveals normal LDL, HDL, Triglycerides and total cholesterol.

- **Depression** (Active)

He has a history of depression with anxiety which is stable with current medication regimen.

Other
- Mild Obesity (Active)
- Spinal Fusion in 2005 (Resolved)

Member Care Plan

Print X

John Doe (8200203)
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Consent: Yes (exp. 1/31/2012)

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Started: 01/17/2011
Last Updated: 06/02/2011

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Social History

Last Updated: 06-17-2011 By: Mary Smith LCC

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Marital Status:	Divorced
Tobacco/Substance/Alcohol Use:	He was a pack a day smoker however he quit smoking in 1985. He reports he rarely uses alcohol.
Nutritional Status:	He is prescribed an 1800 calorie ADA low salt, low cholesterol diet.
Assessment of Activities of Daily Living (ADL):	Self sufficient with ADLs
Mental Health Status (including Cognitive Functions):	He denies feeling depressed and reports enjoying his social outings with friends.
Visual/Hearing Needs:	He wears glasses to read and has no hearing limitations.
Caregiver availability/ involvement:	His support system consists of several close friends and family who live in his community.
Evaluation of cultural and linguistic needs, preferences, or limitations:	Speaks English, no preferences or limitations reported.
External Barriers to meeting goals:	He is independent in activities of daily living. He does cook but enjoys eating out especially for dinner.
Life planning activities:	No Advanced Directives reported
Social Support:	Family support in place
Evaluation of Available Benefits:	He is currently fully insured through CareFirst and has Medicare as a secondary insurance. He has nutritional, behavior health and prescription drug coverage.

Updated
6/17/11
6/02/11
5/12/11
5/01/11
3/31/11
1/10/11

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Family History

Last Updated: 06-17-2011 By: Mary Smith LCC

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- Minimal family history is known.
- He is an only child and both of his parents died when he was a child in an auto accident.
- He was raised by foster care.
- He has two living children, a son and daughter both live in state.

Updated
6/17/11
6/02/11
5/12/11
5/01/11
3/31/11
1/10/11

Member Care Plan

Print

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Consent: Yes (exp. 1/31/2012)

Responsible Lead: Mary Smith LCC
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Medications

Last Approved: 06-17-2011 By: Dr. Robert Miller, PCP
Last Updated: 06-17-2011 By: Mary Smith, LCC

PCP Approved: [ ] Medication Review Complete PCP only

Save Update

Known Allergies

Allergies	Comments
Plavix	Itching

☐ No Known Allergies (NKA)

Add

Medication List

Current | Discontinued

Medications	Dosage	Frequency	Route	Reason	Date Added	
Lovaza	1 g	4 daily	Oral	Diabetes	06/15/2011	Discontinue
Niaspan	1000 mg	Daily	Oral	Diabetes	04/17/2011	Discontinue
Victoza	1.8 mg	Daily	Subcutaneously	Diabetes	03/12/2011	Discontinue
Toprol XL	50 mg	Daily	Oral	Coronary Artery Disease – heart function	01/17/2011	Discontinue
Tricor	145 mg	Daily	Oral	Coronary Artery Disease	01/17/2011	Discontinue
Lipitor	40 mg	Daily	Oral	Coronary Artery Disease – lower cholesterol	01/17/2011	Discontinue
Zetia	10 mg	Daily	Oral	Coronary Artery Disease – lower cholesterol	01/17/2011	Discontinue

Add

Change History

Medication	Change Date	Changed By	Change description
Lovaza	6/15/2011	Mary Smith	**Dosage** updated from **2 g** to **1 g**
Victoza	3/12/2011	Mary Smith	**Frequency** updated from **twice daily** to **daily**

Member Care Plan

Print

John Doe (8200203)
DOB: 12/05/1945
65, Male
Caucasian

Practice: Maryland Family Care
PCP: Dr. Robert Miller
Panel: MP11100123
Consent: Yes (exp. 1/31/2012)

Responsible Lead: Mary Smith LCC
Care Plan Status: In Progress
Started: 01/17/2011
Last Updated: 06/02/2011

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Diagnostic / Lab Results

Last Updated: 06-17-2011 By: Mary Smith LCC

Type: ALL

Date	Type	Test	Outcome/Comments
06/15/2011	Lab	LDL	66
06/15/2011	Lab	HgA1c	10.4
06/15/2011	Lab	Serum Creatinine	1.51 mg/dl
06/15/2011	Lab	BUN	32 mg/dl
06/15/2011	Lab	Glomerular filtration rate	48 ml/min
03/05/2011	Other	EKG	Normal Sinus Rythm

Save Add

Quick Links
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Member Care Plan

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Vital Signs

Last Updated: 06-17-2011 By: Mary Smith LCC

Date	HT	WT	BMI	BP	P	RR	Temp
6/15/2011	6’ 2”	208 lbs	30.4	102/66	60	20	98.0
4/05/2011	6’ 2”	208 lbs	30.4	110/70	65	22	98.1
1/12/2011	6’ 2”	210 lbs	30.6	120/80	70	25	97.9

Save Add

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Care Plan Guideline Evaluation & Measures

Status: In Progress **Last Updated:** January 19, 2011

Guideline Evaluation

To add new measures,please select from listed conditions. To update the current measures,please enter new information in fields below.

☐ Asthma	☑ CAD	☐ CHF	☐ Other
☐ Chronic Back Pain	☐ COPD	☑ Diabetes	
☐ HTN	☐ Pediatric Obesity	☐ Osteoarthritis	

Reset Submit

Care Plan Measures for CAD, Diabetes

Clinical Measure	National Guideline	Patient Goal	Actual	Date	Met
bmi	(Adult: >19 and <25)	32	33.35	08/25/2011	☐
BP	(<130/80-140/90 depending on clinical risk and comorbidities)	130/80	154/100	08/25/2011	☐
LDL	(<130, <100, <70 depending on clinical risk and comorbidities)	Below 70	165	08/25/2011	☐
Antiplatelet therapy		Ecotrin	Ecotrin	05/25/2011	☑
ACE, ARB, ALDO		Ramipril	Ramipril	05/25/2011	☑
B blocker		Metoprolol	Metoprolol	05/25/2011	☑
Tobacco use assessment	(nonsmoker)	Non-Smoker	Non-Smoker	05/25/2011	☑
CAGE screen	(neg)	Negative	Negative	05/25/2011	☑
PHQ (2)	(neg)	N/A	N/A	05/25/2011	☐
Pneumococcal vaccination	(once)	Once	unsure	08/25/2011	☐
Influenza	(annual)	Annual	unsure	10/25/2011	☐
Exercise prescription		Yes	Yes	05/25/2011	☑
Guideline recommended diet		DASH	Low Na	08/25/2011	☐

Applicable Guideline Adherences: CAD , HTN

Member Care Plan

Print

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Clinical Summary
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Quick Links
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Encounter History

Add

Type: ALL **Date:** Most Recent **By:** ALL

Date: 06/29/2011 1:00 PM **Type:** Phone Call **By:** Mary Smith, LCC

Patient was called to follow-up with referral appointment to Nephrologist. And appointment has been scheduled for 7/6.

Additionally, requested that the patient keep a diary of food intake to submit to provider at next appointment. Verified the patient record of daily blood sugar results. No out of range values noted at this time. Patient offered no concerns or questions at this time. I will follow up with this patient in one week to review compliance with 1800 calorie low salt diet and verify patient's attendance with community diabetic support group.

Date: 06/15/2011 9:15 AM **Type:** Office Visit **By:** Mary Smith, LCC

*Subjective:
"I am checking my blood sugars five times a day and working with an Endocrinologist. My morning finger sticks average around 140. I am receiving diabetic counseling and nutritional support at Dr. Cantero's office from their Diabetic educator." He denies hypoglycemia, dry mouth, fruity breath, polyuria or visual complaints. He last saw his ophthalmologist 8 months ago. He reports taking his medication regularly and on time.

*Objective:
Afebrile, Heart Rate 60, Blood Pressure 102/66, Respirations 20 Pulse Oximetry 99%, Weight 208 lbs, BMI30.4. Fasting Blood sugar today is 132 and remains uncontrolled but improved from previous results. Appearance is appropriate, well nourished and well dressed. He presents in no acute distress, alert and oriented to person, place and time. Pupils are equal and reactive to light and accommodation. Oropharynx is clear with moist intact mucous membranes. Neck is supple with no thyromegaly or jugular vein distention noted.

*Assessment:
Diabetes Mellitus Type II not well controlled- needs improvement and continued follow-up on medication plan with improvement in dietary compliance.
Coronary Artery disease with stable blood pressure, good medication compliance and continued follow-up with cardiologist.
Depression much improved with medication regime and life style changes yet requiring close monitoring.

Member Care Plan

Print

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65, Male
Caucasian

Practice: Maryland Family Care
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Panel: MP11100123
Consent: Yes (exp. 1/31/2012)

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- Add Assessment
- Add Action

Assessment and Plan

Last Updated: 06-17-2011 **By: Mary Smith LCC**

PCP Approved:
LCC Submitted:
Complete Care Plan
Next Review: 9/30/2011

Expand All Collapse All
New Save DRAFT

Assessment

General Assessment:

Diabetes- Continue medication regime as prescribed by endocrinologist. Continue monitoring blood sugars at home and reporting readings to Endocrinologist every day. Increase nutritional support to improve dietary compliance to an 1800 calorie low salt low fat renal diet. Follow-up with the Endocrinologist this month.

Kidney dysfunction- Referral to nephrologists for a complete evaluation. Repeat CMP, Mircoalbumin and creatinine ratio prior to Nephrologist's appointment. Patient to begin a renal diet as soon as possible.

Coronary Artery Disease- Encourage to maintain exercise routine, monitor weight loss, and check his blood pressure weekly. Patient to weight himself weekly and notify PCP of any 5 lb weight gain. Repeat CMP and Lipid profile prior to next visit in 3 months.

Medication Assessment:

CAD - Decrease Toprol XL from 100 mg tablet to 50 mg tablet, extended release once a day as blood pressure is stable. Continue to hold Cozaar 10 mg since hospitalization till reevaluation by Cardiologist. Add Altace 10 mg once a day to current medication regime until evaluated by Cardiologist.

Plans

Remove Add

Priority	Key Problems	Plan	Compliance
▼	Diabetes	*Continue medication regime as prescribed by endocrinologist. Continue monitoring blood sugars at home and reporting readings to Endocrinologist every day. Increase nutritional support to improve dietary compliance to an 1800 calorie low salt low fat renal diet. Follow-up with the Endocrinologist this month. Referral for annual Ophthalmology follow-up in October. Patient to schedule annual dental exam. Encouraged to attend diabetic support group meetings at the diabetic education center to improve knowledge and gain meal planning tips. Repeat Hg AIC and fasting serum glucose in one month. Follow-up PCP visit in three months. *Management of Diabetes: LCC to assess the patient knowledge of diabetes and accuracy in blood glucose monitoring. LCC to arrange for the patient to also forward the daily blood sugar results to her by email for review in addition to the endocrinologist. LCC to keep the PCP informed of the progression of blood glucose monitoring results. LCC will assess the	High

Draft
6/17/11

Completed Care Plans
06/02/11
05/12/11
05/01/11
03/31/11
12/10/10

Member Care Plan

Print X

John Doe (8200203)
DOB: 12/05/1945
65, Male
Caucasian

Practice: Maryland Family Care
PCP: Dr. Robert Miller
Panel: MP11100123
Consent: Yes (exp. 1/31/2012)

Responsible Lead: Mary Smith LCC
Care Plan Status: In Progress
Started: 01/17/2011
Last Updated: 06/02/2011

Current Problem List:
- Diabetes
- Renal/Urinary Disord, NEC
- Coronary Artery Disease

Clinical Summary
Encounter History
Assessment and Plan
Home Based Care
Care Coordination
Member Health Record

Quick Links
- Add Encounter
- Add Assessment
- Add Action

Assessment and Plan -- *Continued from Previous Page*

Priority	Key Problems	Plan	Compliance
▲▼	Renal/Urinary Disord, NEC	*Referral to nephrologists for a complete evaluation. Repeat CMP, Mircoalbumin and creatinine ratio prior to Nephrologist's appointment. Patient to begin a renal diet as soon as possible. *Management of new onset renal disease: LCC to educate the patient on renal diet. LCC to contact the nutritional support center at the Endocrinologist center and inform them of the addition of renal diet restrictions LCC to contact the diabetic education nutritional nurse to ensure the diet plan is changed to include renal diet. LCC to communicate with the member bi-weekly to assess for signs and symptoms of urinary difficulty or renal failure.	High
▲	Coronary Artery Disease	*Decrease Toprol XL from 100 mg tablet to 50 mg tablet, extended release once a day as blood pressure is stable. Continue to hold Cozaar 10 mg since hospitalization till reevaluation by Cardiologist. Add Altace 10 mg once a day to current medication regime until evaluated by Cardiologist. *Management of Coronary Artery disease: LCC will assess the embers knowledge of Coronary artery disease, identify the knowledge gaps and provide education. This will include the etiology of the disease, the importance of blood pressure and...	High

Actions

Type: ALL Status: Active Add

#	Type	Action	Review By	Status
1	Phone Call	Contact diabetic counsel/ nutritional support center and inform of addition of renal restrictions to prescribed diet.	06/15/2011	Active
2	Self Care	Review and assess daily blood glucose monitoring results, weekly weights and blood pressures reporting significant findings to the PCP promptly	06/20/2011	Active
3	Appointment	Referral to Nephrologist with appointment scheduled and completed within 14 days.	06/24/2011	Active

Member Care Plan

Print X

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▶ Coordination Team
Contact Info
Member Health Record

Quick Links
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- Add Assessment
- Add Action

Coordination Team

Last Updated: 06-17-2011 By: Mary Smith LCC

Primary Care Provider

PCP Name:	Dr. Robert Miller
Practice Name:	Maryland Family Care
PCP Address:	457 Old Towne Rd Baltimore, Md. 21131
PCP Phone Number:	410-929-1231
Provider ID:	83940001
Panel ID:	11100123
Panel Segment:	L01
E-mail Address:	drmiller@gmail.com

Care Coordination Team

View History

Regional Care Coordinator:	Joanne Wilson 410-998-1393 joanne.wilson@carefirst.com
Local Care Coordinator: Responsible Lead as of: 06-17-2011	Mary Smith 410-998-1344 mary.smith@abc.com
Customer Service Rep:	Tom Gordon 410-998-1322 tom.gordon@carefirst.com
Case Manager:	Bob Jones 410-123-1234 bob.jones@carefirst.com
HTC:	Jane Cooper 410-123-1236 jane. cooper@xyz.com

Additional Physician Info

Physician Name	Specialty	Phone	E-mail	Notes

Add

Undo Save

Member Care Plan

Print

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Contact Info

Last Updated: 06-17-2011 By: Mary Smith LCC

Relationship to Subscriber: Self

Contact:	Address:	Home Phone:	Work Phone:	Mobile:	Email:	Comments:	Preferred:
John Doe (Enrollment Record)	123 Main Street Apt 3B Baltimore, MD 21131	410-929-1245	410-737-3201	443-929-1345	jdoe@gmail.com		○
Jane Doe		410-929-0001				Staying at Daughters' this summer	●

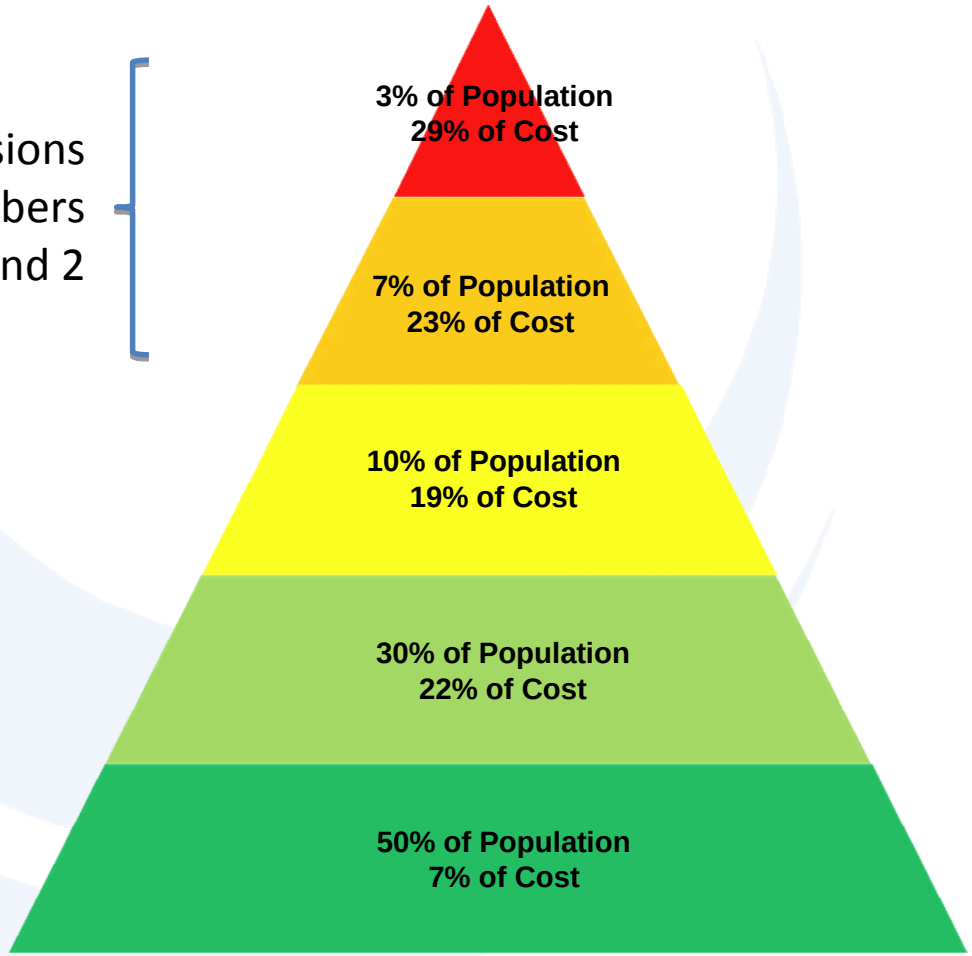
Delete | Save | Add Alternate Contact Info

Font Style | Lists | check spelling | Undo | Save

Patient has given permission for his Daughter Jane Doe to receive updates for Care Coordination purposes. Use the home phone noted as preferred, or his cell phone for contact.

Illness / Wellness Pyramid – 2010 CareFirst Experience

77% of admissions were for members in bands 1 and 2



Advanced Illness

Multiple Chronic Conditions

At Risk

Stable

Healthy

Source: CareFirst Health Care Analytics